CHAPTER 2

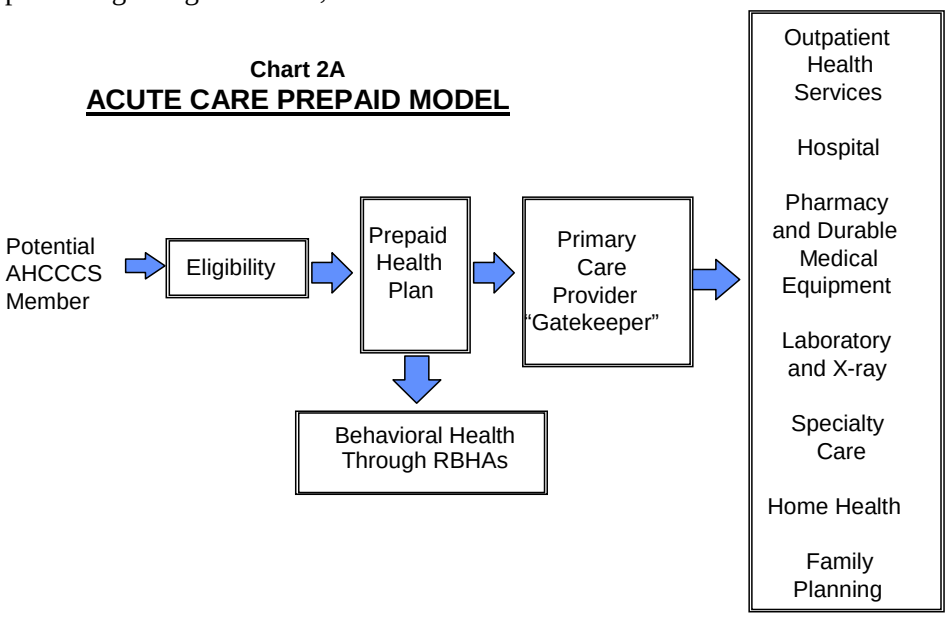
ACUTE CARE PROGRAM

The AHCCCS acute care program is a statewide, managed care system which delivers acute care services through eight prepaid, capitated Health Plans. As of October 1, 2005, AHCCCS' Health Plans were delivering managed care to 851,380 Medicaid members. The Title XXI program, KidsCare, is covered in Chapter 4. The Healthcare Group is covered separately at the end of this chapter.

Chart 2A depicts the acute care prepaid model. Access to care has been a major goal of AHCCCS since the program began in 1982. In May 2003, AHCCCS awarded acute care contracts to eight contractors for a three-year period beginning October 1, 2003. Most acute care contracts are awarded by Geographic Service Area (GSA), of which there are seven. In addition, AHCCCS awards contracts on a non-competitive basis to the Comprehensive Medical and Dental Program, a Managed Care Organization for children in foster care, and the Children's Rehabilitative Services Administration, a program administered by the ADHS office for Children with Special health care needs (OCSHCN).

Chart 2A

ACUTE CARE PREPAID MODEL



The mainstreaming of members into the private physician sector is the direct result of a working partnership between AHCCCS and its contracted Health Plans. Mainstreaming members is a critical element in the success of the acute care program. The AHCCCS network also includes Federally Qualified Health Centers (FQHC) which further expand access to health care in medically underserved areas.

Eligibility for the AHCCCS acute care program is based on federal requirements, Arizona Revised Statutes (http://www.azleg.state.az.us/ArizonaRevisedStatutes.asp) and Arizona Administrative Code (http://www.azsos.gov/public_services/Table_of_Contents.htm). Appendix I displays the current AHCCCS eligibility requirements for all major eligibility groups.

ELIGIBILITY

Medicaid Groups

As of September 30, 2005, AHCCCS covered the following groups of people under the Medicaid Program:

- Families and children described in Section 1931 of the Social Security Act
- Individuals or couples without dependent children with income at or below 100 percent FPL
- Individuals or families who incur sufficient medical expenses that, when deducted from their income, reduces their income to under 40 percent of the FPL
- Pregnant women with income at or below 133 percent FPL

- Children under age one with family income at or below 140 percent FPL
- Children ages 1 thru 5 whose family income is at or below 133 percent FPL
- Children ages 6 thru 18 whose family income is at or below 100 percent FPL
- Children who are eligible for Title IV-E Foster Care or Adoption Subsidy
- Newborns of mothers who were receiving Medicaid when the children were born
- Individuals who are aged, blind or disabled with income at or below 100 percent FPL
- Persons under age 21 who were in foster care on their 18th birthday
- Persons who meet the requirements of one of the categorically-linked Medicaid programs. Persons who do not meet citizenship or qualified immigrant status receive emergency services only
- Persons eligible for the Medicare Savings Programs (QMB, SLMB, QI 1's)
- Women under age 65, diagnosed as needing treatment for breast or cervical cancer
- Parents of children eligible for Title XIX or XXI with income between 100% and 200% FPL
- Working, disabled persons over age 16 and under age 65 with income below 250% FPL (Freedom to Work)
- Children eligible for Title XXI with income between 100% and 200% FPL

The Arizona Department of Economic Security (DES) processes applications and determines eligibility for most acute categories. The Social Security Administration determines eligibility for SSI-related groups, and AHCCCS determines eligibility for the Medicare Savings Programs, women diagnosed with breast or cervical cancer, Freedom to Work recipients, and parents of children eligible for Title XIX or XXI, as well as Title XXI children. Appendix II displays the enrollment numbers for the various covered groups from 1982 to present.

SERVICES

Appendix III lists the numerous services provided to AHCCCS members.

Behavioral Health Services

When the AHCCCS program began in 1982, the State decided to delay the implementation of behavioral health services until the new Medicaid program stabilized. In 1990, AHCCCS began phasing in comprehensive behavioral health services, starting with seriously emotionally disturbed (SED) children under the age of 18 who required residential care. Over the next five years other populations were added, including non-SED children in 1991, adults with serious mental illness (SMI) in 1992 and adults needing general mental health and/or substance abuse services in 1995.

Behavioral health services for all acute care Medicaid and KidsCare eligible persons are administered under contract with the Arizona Department of Health Services (ADHS) who subcontracts with the following four Regional Behavioral Health Authorities (RBHAs) and four tribal RBHAs to provide services:

- Cenpatico Behavioral Health of Arizona serves Yuma, LaPaz, Pinal and Gila counties
- Community Partnership of Southern Arizona (CPSA) serves Pima, Cochise, Graham, Greenlee and Santa Cruz counties;
- Northern Arizona RBHA (NARBHA) serves Mohave, Coconino, Navajo, Yavapai and Apache counties;
- Value Options serves Maricopa County;
- Pascua-Yaqui Tribal RBHA provides services to Pascua-Yaqui tribal members;

- Gila River Tribal RBHA provides services to Gila River tribal members;
- Navajo Nation Tribal RBHA provides services to Navajo Nation tribal members; and
- Colorado River Tribal RBHA provides services to Colorado River tribal members.

Behavioral health services for individuals 18-20 years, who were not seriously mentally ill, were provided through the AHCCCS Health Plans until October 1, 1999. Legislation was passed in 1999 that enabled these AHCCCS members to receive behavioral health services through the RBHAs, the same as other AHCCCS members. On September 30, 2005, there were 81,592 AHCCCS members enrolled with ADHS.

For more detailed information on Behavioral Health Services, please refer to the Behavioral Health Services Guide at:
http://www.ahcccs.state.az.us/Publications/GuidesManuals/BehavioralHealth/index.asp.

Targeted Case Management

In early 1998, a targeted case management program was implemented for individuals who are developmentally disabled, meet the financial requirements of Title XIX and need case management support, but do not qualify for the long-term care program. Case managers employed by the Department of Economic Security/Division of Developmental Disabilities (DES/DDD) intervene to ensure that the changing needs of the member and family are recognized on a continual basis and that the widest array of appropriate options are presented for meeting those needs.

SERVICE DELIVERY

AHCCCS was the first statewide, managed care Medicaid program in the nation to rely solely on contracted Health Plans to deliver acute care services to both Medicaid and state-funded populations. Financing for the program is based on a prepaid capitation approach, with the AHCCCS Health Plans assuming the financial risk for the delivery of services. AHCCCS Health Plans are defined by state statute and are regulated and monitored by AHCCCS based on strict financial and operational standards.

For the contract year beginning October 1, 2003, AHCCCS acute-care contracts were awarded for a three-year period, with two one-year renewal options. In order to secure an AHCCCS contract, prospective contractors responded to a Request For Proposal (RFP) by submitting a bid that included proposed capitation rates for all AHCCCS services. During the contract negotiation process, prospective contractors that responded to the RFP segregated their bids by selected geographic service areas, specifying fixed, per member, per month capitation rates based on member rate codes. Critical elements in the bid evaluation performed by AHCCCS included an assessment of how each prospective contractor would meet all financial and operational requirements, ensure quality in the delivery of services and provide a sufficient provider network to meet provider accessibility requirements. AHCCCS also evaluated each capitation proposal based on capitation rate ranges, which had been actuarially established to determine whether the bid was too high for the actuarial range or too low for the delivery of quality services. Once a Health Plan was awarded a contract, services had to be available and accessible to the enrolled members based on performance standards specified in the contract. Exhibit 2.1 provides information on the Health Plans contracted with AHCCCS as of October 1, 2005. Exhibit 2.2 presents the Health Plans and their total enrollment by county. AHCCCS monitors each Health Plan for compliance with the contract as discussed more fully in Chapter 5.

AHCCCS allows members to choose a Health Plan from those available in the GSA in which the member resides. After choosing a Health Plan, the member must then choose a primary care provider who is affiliated with that Health Plan. Historically, approximately 60 percent of all Medicaid members select a Health Plan. If the member does not select a Health Plan, AHCCCS automatically assigns the person to an available Health Plan in the member's GSA.

All members have an extensive choice of primary care providers since many licensed physicians and practitioners choose to participate in AHCCCS. In the rural areas of the State, the choice is generally more limited due to a general shortage of providers.

The role of the primary care provider is critical to the success of the program since they provide all medical care and arrange referrals for specialty care. There are currently three exceptions:

- Dental services for children do not require authorization from the primary care provider,
- The network for the behavioral health system uses RHBAs for behavioral health services, and
- Women can elect an OB/GYN provider as their primary care provider.

Once members choose, or are assigned to a Health Plan, they are "locked-in" to that Health Plan until their enrollment anniversary date. During the annual enrollment period, members are given a 30-day period in which they can change Health Plans. AHCCCS allows an exception to the lock-in period primarily to provide for medical or family continuity of care. Historically, the number of members electing to change Health Plans has been low. This past year, the number of members who changed Plans during open enrollment averaged about three percent. In 1998, AHCCCS transitioned from the traditional one month open enrollment period, to an annual enrollment choice, which allows members to choose a Health Plan on the anniversary date of their individual enrollment.

Native Americans who utilize acute Medicaid or SCHIP benefits in Arizona have the option to select either utilization of the Indian Health Service (IHS) system or an AHCCCS Health Plan. If the member chooses IHS, all available services are provided through the IHS or a tribal facility on a Fee-For-Service basis (FFS). If a covered service is not available through IHS or if IHS does not have funding to pay for the service, the member may obtain services on a FFS basis through AHCCCS. A member who has chosen IHS may change to an AHCCCS Health Plan at any time. Similarly, a member who has chosen a Health Plan can also utilize IHS services. On October 1, 2005, there were 84,621 Native Americans using IHS as their provider of acute care medical services.

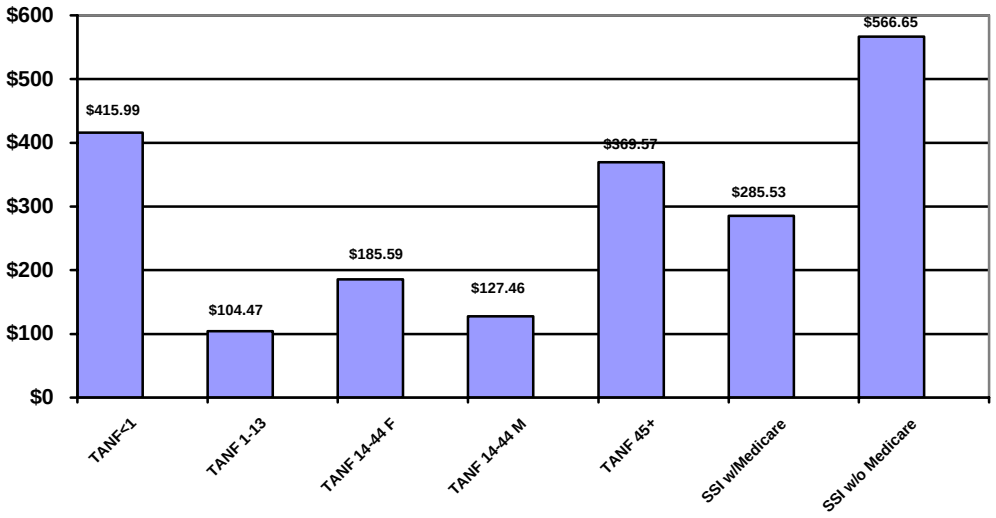
Except for those Native Americans who choose the IHS as their provider or foster children enrolled in the Comprehensive Medical and Dental Plan (CMDP), all members are guaranteed eligibility for an initial five-month continuous period in addition to the month the member was enrolled. This guaranteed enrollment period is important to the member and the Health Plan for two reasons: (1) the member has the security of continuous health care for at least five months; and (2) the Health Plan has an opportunity to stabilize medical conditions and reduce their financial risk for sick members through the assurance of at least five months of capitation payments.

HEALTH CARE CAPITATION

AHCCCS contracted Health Plans are prospectively paid a fixed monthly capitation, adjusted for various risk factors, such as the age and gender of each member. AHCCCS uses actuaries to develop the rate ranges, not the actual rates, that are the bases for the capitation rates. When a Health Plan submits a bid to participate in the AHCCCS program, it agrees to provide a specified set of services to any individual within the geographic area for the capitation rate established by their contract with AHCCCS. Under this arrangement, Health Plans are at-risk for the services provided to a member since they must absorb the loss if the medical costs for a member exceed the monthly capitation payment made to the Health Plan. Reinsurance, which provides some measure of financial protection against significant medical costs to the Health Plans, is discussed in Chapter 5.

The capitation rates for seven acute care rate groups are provided in Chart 2B. The statewide average capitation rates in Chart 2B do not include FFS, reinsurance or Medicare premiums.

Chart 2B



PROGRAM FUNDING

AHCCCS is funded by a combination of federal, state, and other funds as reflected in Appendix IV. For all Medicaid members, CMS pays a federal match to the state based on the matching percentage established annually in federal regulation, effective at the beginning of each federal fiscal year. For the federal fiscal year beginning October 1, 2004 through September 30, 2005, the Title XIX_federal contribution was 67.45 percent. The state contribution was 32.55 percent and was paid with a combination of General Fund monies, a fixed contribution from each county, and tobacco-related dollars. The federal government pays an enhanced match for Title XXI programs, including KidsCare and HIFA parents. For federal fiscal year 2005, the Title XXI federal contribution was 77.22%.

HEALTHCARE GROUP

In addition to participating in the AHCCCS program, three Health Plans participate in Healthcare Group, which was created by the Legislature to provide an affordable health care option for small employers. As of October 1, 2005, this organization served approximately 16,624 Arizona employees and their dependents (see Chart 2C). Self-employed individuals or employers with 50 or fewer employees are eligible to purchase health care for themselves, their employees and the employee's dependents through the participating Health Plans. Employers may have a choice of Health Plans depending on the county in which the business is located. Employers will have a choice of benefit levels with varying cost sharing options.

Chart 2C

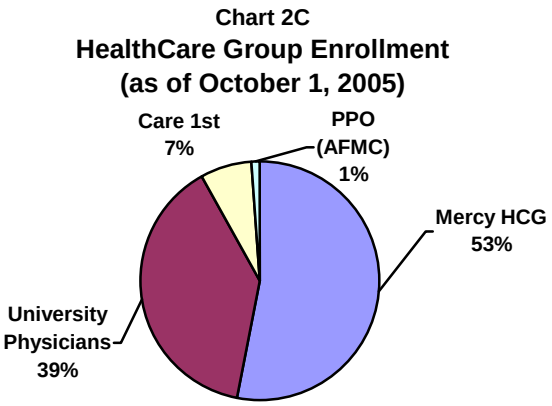
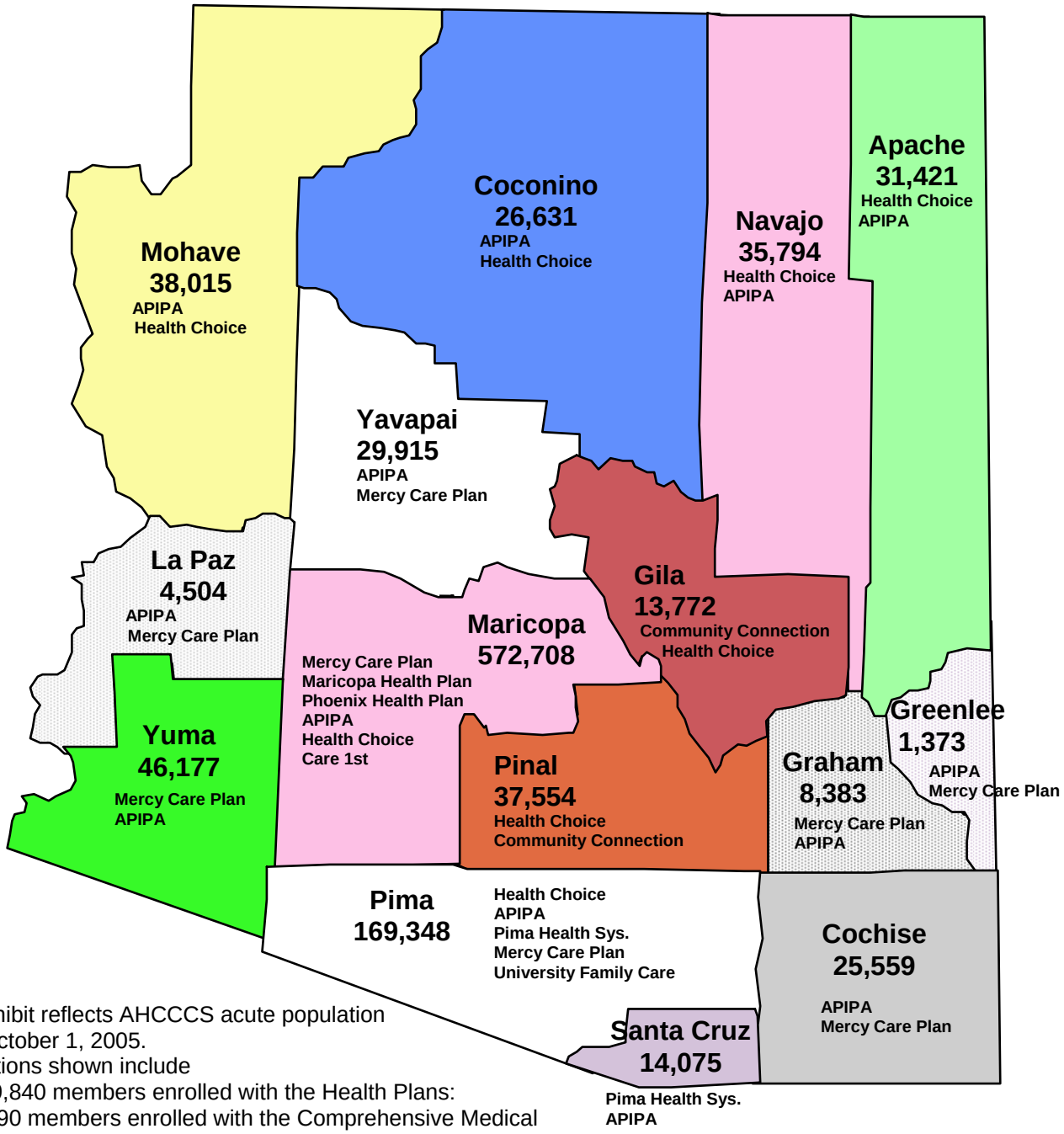


Exhibit 2.1
AHCCCS HEALTH PLANS
(As of October 1, 2005)

NAME	OWNER/OPERATOR	CORPORATE STRUCTURE	DATE OPERATIONS COMMENCED	COUNTIES OF OPERATION	ENROLL-MENT
Arizona Physicians IPA	Americhoice/UnitedHealth Group	Corporation For profit	10/1/82	Apache, Cochise, Coconino, Graham, Greenlee, LaPaz, Mohave, Maricopa, Navajo, Pima, Santa Cruz , Yavapai, Yuma	283,788
Care 1st Healthplan Arizona	Care 1st Health Plan	Corporation For profit	10/01/03	Maricopa	30,742
Comprehensive Medical and Dental Program	Department of Economic Security, State of AZ	Government Not for profit	10/1/90	Statewide	9,590
Health Choice Arizona	IASIS Healthcare Corporation	Corporation For profit	10/1/90	Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pima, Pinal	113,589
Maricopa Health Plan*	Maricopa County Special Health Care District	Statutory Special Health Care District Not for profit	10/1/05	Maricopa	35,674
Mercy Care Plan	Catholic Healthcare West Arizona Carondelet Health Care Group (Tucson)	Corporation Not for profit	10/1/83	Cochise, , Graham, Greenlee, La Paz Maricopa, Pima, , Yavapai, Yuma	242,722
Phoenix Health Plan/ Community Connection	Abrazo Healthcare	Corporation For profit	10/1/83	Gila, Maricopa, Pinal	96,172
Pima Health Plan	Pima County Government	Government Not for profit	10/1/82	Pima, Santa Cruz	27,586
University Family Care	University Physicians Inc.	Corporation Not for profit	10/1/97	Pima	11,515

Note:
Exhibit 2.1 provides information on the health plans contracted with AHCCCS as of October 1, 2005
*Change in ownership in 2005 which resulted in new Plan ID.

Exhibit 2.2
AHCCCS and KidsCare Members by County and AHCCCS Health Plans by County
(October 1, 2005)



Note:
The exhibit reflects AHCCCS acute population as of October 1, 2005.
Populations shown include

- 859,840 members enrolled with the Health Plans:
- 9,590 members enrolled with the Comprehensive Medical and Dental Plan (CMDP);
- 160,202 individuals receiving services on a fee-for service basis (I.e. emergency services and IHS); and
- 2,035 QMB Only individuals.